VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

April 30, 2014

Ms. Catherine Rooney, Administrator
Owen House, Ltd
3 Union Street
Fair Haven, VT 05743-1028

Dear Ms. Rooney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 30, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0382	A. BUILDING: _____ B. WING _____	C 01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWEN HOUSE, LTD	3 UNION STREET FAIR HAVEN, VT 05743

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R100	Initial Comments: An unannounced onsite investigation of a complaint was initiated on 1/13/2014 by the Division of Licensing & Protection, and concluded on 1/30/14 after further offsite gathering of information. The following regulatory deficiencies were cited as a result of the investigation:	R100	Please see attached document for full plan of corrections for R126 through R153.	
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed to arrange necessary services for one resident Resident #6 (R#6) for medical services of a worsening wound. Findings include: Per record review for Resident #6, a wound of the Left (L) heel was first noted in records on 12/19/13. The nurses note does mention the wound as a superficial wound and instructions were to cleanse and cover the wound. In the direct caregiver Daily Log on 12/23 the wound is described as swollen and hot. On 12/25 the L heel wound was described as hot and swollen with a foul drainage. The drainage is described in notes as continuing and increasing with a note on 1/1/14 stating that the drainage had soaked	R126	The nurse will be notified of any medical need of a resident. The resident will then be seen by their primary doctor immediately. Nurse will then be notified of any care plan	

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R126	Continued From page 1 through the dressing and the sock. On 1/2/14 a note stated that the resident complained of pain in his/her L foot. The notes written by unlicensed day staff state that the L foot was soaked daily. In an interview on 1/13/14 at 10:35 AM, the caregiver on duty stated that s/he had soaked the resident's foot in warm water (after removing the dressing). S/he stated that then the foot was elevated in a recliner to await the manager's arrival to put the dressing on. In an interview at 11:40 AM, the Manager stated that the usual procedure to care for the wound is that the day staff remove the dressing and soak the foot and then s/he comes and applies a new dressing. This procedure was not found any where in the notes, orders, or care plan. S/he stated that the soak solution is a combination of warm tap water and table salt that "we always use". S/he stated that the resident had not seen his/her physician for the wound but did have an appointment the following week for a routine neurology check. In an interview at 12:38 PM, the facility nurse stated that when s/he saw the wound on 12/19/13 the wound was small enough to be covered by a Band-Aid. S/he stated that the wound was cleansed with saline and a Band-Aid applied. The nurse had not returned to the facility since 12/19 and usually visits once monthly and as needed. S/he would usually come to the facility toward the end of the month. S/he stated that the facility staff had not notified him/her of the changes in the wound and s/he was not aware that the wound was reddened, swollen, and draining. S/he stated that s/he had not notified the resident's physician of the wound and had not suggested that an appointment be arranged based on the information s/he had.	R126	changes in regards to that resident per doctors orders. This corrective plan was immediately started.	

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R145	Continued From page 2	R145		
R145 68=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assure that the written plan of care describes care and services necessary to maintain well-being for three residents (Residents #2, #6 & #7). Findings include: 1). Per record review, Resident #2, according to notes, was in the kitchen searching the cupboards for cookies on 12/20/13 and stuffing food into his/her clothes on 1/2/14 when staff stopped him/her and escorted him/her from the kitchen. There is no documentation in the care plan regarding the resident's behaviors. In interview on 1/13/14 at 11:45 AM, the Manager stated that it was common for this resident to hoard and try to gather food and other items in the room. In an interview at 12:38 PM, the facility nurse stated that the behavior was not reported to him/her and that s/he had not care planned for that behavior. 2). Per record review of nurse's monthly notes, Resident #6 has a wound on the L heel. The nurse did write a note on 12/19 stating that the wound was to be cleansed and covered as	R145	Care plans will also describe behaviors of the resident & how staff can assist resident to maintain a safe and healthy home for the resident Updated care plans will be completed by 3/15/2014	

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R145	Continued From page 3 needed. There was no update the the written plan of care regarding the worsening wound or care that should be provided for the wound. Additionally R#8 had monthly weights recorded in the nurses notes (but not on the monthly flowsheet). There is one weight per month found in the record for September, October, and November, and no weights listed for December or January. The recorded weights reflect a 61 day weight loss of 14 pounds or a 5.6% weight loss. There was no revision of the care plan to reflect weight loss or provide strategies for maintaining weight. 3). Per record review of nurse's monthly notes, Resident #7 had monthly weights recorded in the nurses notes (but not on the monthly flowsheet). The weights are as follows- 9/13: 186#, 10/13: 180#, 11/13: 176# and 12/13: 170#, and there are no weights listed for January. The recorded weights reflect a 61 day weight loss of 10 pounds or a 5.2 % weight loss and a 90 day weight loss of 16 pounds or an 6.4% weight loss. There was no revision of the care plan to reflect weight loss or provide strategies for maintaining weight.	R145	monthly flow sheet will have recorded weights the 1st wk (1-15) of the month and the 3rd wk of (15-30) the month this was taken care of immediately	
R146 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff	R146		

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R146	Continued From page 4 Interview the facility failed to assure that the nurse provided instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs as appropriate, for Residents #6 & #7 (R#6, R#7). Findings include: 1). Per record review, R#6 had a wound on his/her Left (L) heel discovered on 12/19/13. The nurses note written on that date states that the wound should be cleansed and covered as needed. The written plan of care does not contain information regarding treatment of the wound. In a review of the caregivers Daily Log book it is stated that R#6's foot is soaked and elevated. In an interview on 1/13/14 at 10:45 AM, the direct caregiver staff on duty stated that s/he was directed by the manager to soak the foot and leave it elevated and open to air daily to await him/her application of a dressing. S/he stated that the nurse had not provided any instruction regarding the wound. In an interview at 11:45 AM, the facility manager stated that s/he had not contacted the facility nurse to report the wound changes or receive additional instruction. The facility nurse acknowledged that s/he became aware of a wound on the L heel of the resident, with lower extremity Neuropathy, on 12/19/13 and that s/he had not been back to the facility as of this date (1/13/14), nor had s/he called for an update on the condition of the wound. S/he also stated that s/he had made no revision of the care plan regarding the wound and the interventions required. 2). Per record review Residents #6 & #7 both has significant weight loss during the period of	R146		

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R146	Continued From page 5 9/13/13 to present. There were no notes regarding the weight loss by the nurse and there were no revisions to either resident's care plan. The direct care staff on duty stated in an interview at lunch time that s/he had not received any instruction regarding any residents at risk for weight loss.	R146		
R149 SS=E	V. RESIDENT CARE AND HOME SERVICES 6.9.c (6) Maintain a current list of all treatments for each resident that shall include: the name, date treatment ordered, treatment and frequency prescribed and documentation to reflect that treatment was carried out; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that a current list of all treatments was maintained for Resident #6 (R#6) receiving wound care. Findings include: Per record review, R#6 had a wound on the bottom of his/her Left heel discovered on 12/19/13. The nurses note written on that date states that the wound should be cleansed and covered as needed. There is no Physician's Order for wound treatment. In a review of the caregivers Daily Log book it is stated in notes that R#6's foot is soaked and elevated. In an interview at 10:45 AM the direct caregiver staff on duty stated that s/he was directed by the manager to soak the foot and leave it elevated and open to air daily to await his/her application of a dressing. S/he stated that the nurse had not	R149		

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R149	Continued From page 6 provided any instruction regarding the wound. In an interview at 11:45 AM the facility manager stated that s/he had not contacted the facility nurse to report the wound changes or receive additional instruction. S/he stated that there was no written list of the wound treatment available and that documentation of the wound care is in the Caregiver Log.	R149		
R150 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that all symptoms or signs of illness were recorded at the time of occurrence, along with actions taken for 2 Residents (Resident #6 & #7). Findings include: 1). Per record review and staff interview, two residents experienced significant weight loss. Resident #6 had monthly weights recorded in the nurses notes (but not on the monthly flowsheet). The weights are as follows- 9/13: 250 lbs, 10/13: 240 lbs, and 11/13: 236 lbs. There are no weights listed for Dec 2013 or Jan 2014. The recorded weights reflect a 61 day weight loss of 14 pounds or a 5.6% weight loss. Resident #7 had monthly weights recorded in the nurses notes (but not on the monthly flowsheet).	R150	Resident #6 was working at losing weight as recommended by his physicians I will make sure that dr. orders & care plans reflect this from now on	

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R150	Continued From page 7 The weights are as follows- 9/13: 186 lbs, 10/13: 180 lbs, 11/13: 176 lbs and 12/13: 170 lbs. There are no weights listed for Jan 2014. The recorded weights reflect a 61 day weight loss of 10 pounds or a 5.2% weight loss and a 90 day weight loss of 16 pounds or an 8.4% weight loss. In a review of the nursing notes the weights are listed monthly but there is no documentation of the significant weight loss and a plan for action. There is no indication of notification of the MD or instruction to staff regarding weight maintenance strategies or notification of nurse or MD. 2). Per record review, a wound is noted for R#6 on the left heel on 12/19/13 but there is no description of exact location, size, or color of the wound in the notes nor any indication of instructions to staff as to notification of nurse and MD for changes in wound and treatment procedures.	R150		
R153 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (10) Monitor stability of each resident's weight; This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to assure that the stability of each resident's weight was monitored for Residents #6 & #7. Findings include: 1). Per record review and staff interview, two residents experienced significant weight loss. Resident #6 had monthly weights recorded in the	R153		

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R153	Continued From page 8 nurses notes (but not on the monthly flowsheet). The weights are as follows- 9/13: 250 lbs, 10/13: 240 lbs, and 11/13: 236 lbs. There are no weights listed for Dec 2013 or Jan 2014. The recorded weights reflect a 61 day weight loss of 14 pounds or a 5.6% weight loss. Resident #7 had monthly weights recorded in the nurses notes (but not on the monthly flowsheet). The weights are as follows- 9/13: 186 lbs, 10/13: 180 lbs, 11/13: 176 lbs and 12/13: 170 lbs. There are no weights listed for Jan 2014. The recorded weights reflect a 61 day weight loss of 10 pounds or a 5.2% weight loss and a 90 day weight loss of 16 pounds or an 8.4% weight loss. In a review of the nursing notes the weights are listed monthly but there is no documentation of the significant weight loss and a plan for action for either resident. There is no indication of notification of the MD or instruction to staff regarding weight maintenance strategies or notification of nurse or MD. Additionally there is no record of re-weighs or increase of the frequency of weighing for residents with significant weight loss.	R153	Resident #7 had been to his physician between the recorded weights & did not mention any problems in this regard forcus to address	
R219 SS=D	VI. RESIDENTS' RIGHTS 6.7 Residents have the right to reasonable access to a telephone for private conversations. Residents shall have reasonable access to the home's telephone except when restricted because of excessive unpaid toll charges or misuse. Restrictions as to telephone use shall be in writing. Any resident may, at the resident's own expense, maintain a personal telephone in his or her own room.	R219		

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R219	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure the resident's right to reasonable access to a telephone for private conversations for Resident #2, Findings include: Per record review of Caregiver log notes stated that Resident #2 was upset and demanded to use the telephone. The noted stated that the staff denied him the use of the telephone because "I wasn't sure he was allowed to use it". In an interview on 1/13/14 the manger acknowledged that the residents had not been allowed to use the phone because staff didn't know who he was calling or if it was allowed.	R219	Residents do have access to the house phone for local calls, each call limited to 10 minutes No long distance or 800#s Each room has the capability for a private phone line at the residents expense This will be addressed more explicitely in the resident agreement from now on R219 POC accepted 1/29/13 MHiggins RN/PMC	
R227 SS=E	VI. RESIDENTS' RIGHTS 6.15 Residents have the right to refuse care to the extent allowed by law. This includes the right to discharge himself or herself from the home. The home must fully inform the resident of the consequences of refusing care. If the resident makes a fully informed decision to refuse care, the home must respect that decision and is absolved of further responsibility. If the refusal of care will result in a resident's needs increasing beyond what the home is licensed to provide, or will result in the home being in violation of these regulations, the home may issue the resident a thirty (30) day notice of discharge in accordance with section 5.3.a of these regulations. This REQUIREMENT is not met as evidenced	R227		

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R227	Continued From page 10 by: Based on record review and staff interview, the facility failed to assure that resident's rights were followed for residents of the facility regarding the right to refuse treatment for Resident #2. Findings include: Per record review of the Caregiver log, on 12/20/13 Resident #2 requested his cookies stored in the kitchen. Since it was not snack time the staff on duty refused to give them to him. In an interview the facility manager stated that the facility maintains all residents on a heart healthy diet. Additionally Resident #2's notes reflect several occasions when the resident wanted to leave the facility to go for a walk and staff instructed him he must return to the facility and that he was not allowed to leave the facility grounds. In an interview on 1/13/14 the facility manager stated that the restriction of additional snacks was an attempt to keep residents on a healthy diet. S/he additionally stated that the resident was restricted to the facility grounds to prevent the resident from relapsing after detoxing from alcohol abuse. There were no MD orders supporting these interventions. It was pointed out that regardless of reason the resident maintains the right to refuse to comply with restrictions.	R227	We will put into place a written contract (Safety) w/resident on why some restrictions are in place for that residents safety & that by not complying with the contract that they would be in jeopardy of losing their placement from the home w/ a 30day written notice of discharge R227 POC accepted 4/29/14 Mitchgins RN/PMC	
R315 SS=D	XI. RESIDENT FUNDS AND PROPERTY 11.3 The personal property of the resident shall be available for the resident's use and securely maintained when not in use.	R315		

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R315	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to assure that personal property was available for Resident #2's use. Findings include: Per review of Caregiver Log notes on 12/21/13 Rogaine and hair dye was discovered in Resident #2's room and removed and locked away. A note states that the resident requested his Rogaine and dye back and the caregiver refused to give it back because "I wasn't sure he was allowed to have it".	R315	We will revise our agreements house rules that no ~~over~~ counter medications (vitamins, hair coloring, any chemical products) are not allowed in bedrooms residents may access ~~the~~ hair products by asking staff for them to use. All products will be locked in office for everyones safety R315 POC accepted 4/29/13 M Higgins RN/PMC	

Corrective Action Plan

Owen House - RAVNAH

V. Resident Care and Home Services:

(R128) 5.5 General Care: Upon a resident's admission to a Residential Care Home, necessary services shall be provided or arranged to meet the Resident's personal, psychological, nursing and medical needs.

Nursing Oversight Policy to be developed/reviewed/implemented with Facility. RN and House Manager will sign policy and policy will be kept on file at RCH. Completion date 05/01/2014. Policy to be reviewed annually. Monitored ongoing during site visits to the facility by RN and direct observation, chart review, and interview with RCH Staff.

Contracted RN to increase visits to the facility. Completion date 01/24/14 and ongoing.

R128 POC accepted 4/29/14 mHiggins RN/PMC

(R145) 5.9 c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the residential assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being.

(R146) 5.9 c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate.

All Resident's will have an Individualized Care Plan completed within 14 days of admission. Completion date 05/01/14. Care Plan will be reviewed and updated at least annually and/or any time there is a significant change in a resident's physical/mental condition.

Written Behavioral Plans for all Residents have been completed. House Manger to co-sign Written Behavioral Plans. Completion 05/01/04. Written behavioral Plans will be reviewed and updated at least annually and any time there is a significant change in a resident's physical/mental condition Monitored ongoing during site visits to the facility by RN and direct observation, chart review, and interview with RCH Staff/House Manager.

R145 + R146 POC accepted 4/29/14 mHiggins RN/PMC

(R149) 5.9 c (6) Maintain a current list of all treatments for each resident that shall include: the name, date, treatment ordered, treatment and frequency prescribed and documentation to reflect that treatment was carried out.

All Resident's treatments will be on the MARS. Each Resident's treatments on the MARS shall be consistent with the Physicians order. Treatment will be carried out in the same process as medication administration and signed off on the MARS. RCH staff and/or House Manager will contact RN when any change in Residents condition warrants an assessment or treatment change or medication change in a timely manner. **Monitored ongoing during site visits to the facility by RN and direct observation, chart review, and interview with RCH Staff/House Manager.**

R149 POC accepted 4/29/14 mHiggins RN/PMC

(R150) 5.9 c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken.

All Residential Care Home staff to be re-educated on how to access SN for any medical issue that arise for any residents. Completion date 05/01/2014. Monitored ongoing during Site visits to the facility by RN and direct observation, chart review, and interview with RCH Staff/House Manager.

R150 POC accepted 4/29/14 MHqqmsRN/PMC

(R153) 5.9 c (10) Monitor stability of each resident's weight.

RCH Staff will be responsible to weigh residents monthly and record on the RCH house log. RN during site visits will monitor weights and weight/record as needed. Significant weight gains or loss will be communicated to the physician by the RN or House Manager. Dietary intervention may be indicated and implemented based on physician orders. Alternate therapy interventions may also be indicated and implement consistent with physician order and identified on the Resident's Individualized Care Plan. Monitored ongoing during Site visits to the facility by RN and direct observation, chart review and interview with RCH Staff/House Manager.

R153 POC accepted 4/29/14 MHqqMURN/PMC